

**Investigation into the circumstances surrounding the
death of a man at HMP High Down**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

April 2007

This is the report of an investigation into the circumstances of the death of a man at HMP High Down in April 2006 after he was found hanging in his cell in the healthcare unit. Attempts were made to try to resuscitate the man and he was taken to Epsom General Hospital but he died that night. The man was 39 years old.

I extend my sincere condolences to the man's family and friends for their loss.

The investigation was carried out by two of my investigators. A review of the man's clinical care and treatment was carried out by a senior nurse from East Elmbridge and Mid Surrey Primary Care Trust (PCT). A review of the management of the man's alcohol dependence was carried out by Prison Health Unit of the Department of Health.

I would like to thank all those who have assisted, including the Governor of High Down and his staff.

The man had been remanded into High Down two days before his death, accused of attempted murder. It was his first time in custody. He also told staff that he had committed acts of self-harm in the past (albeit he consistently said he had no such thoughts at present). He was located in the healthcare unit for alcohol detoxification. Taken together, these are all risk factors for self-harm. Nevertheless, in the two days the man was in High Down, I judge there was nothing specific about his behaviour to alert staff that he was considering harming himself or taking his own life.

Following the man's death, a farewell letter to his partner was found in his cell.

I have made five recommendations. Three of these concern emergency response procedures. The remaining two recommendations are about clinical record keeping.

Stephen Shaw CBE
Prisons and Probation Ombudsman

April 2007

SUMMARY	4
INVESTIGATION PROCESS.....	6
HMP HIGH DOWN.....	7
EVENTS LEADING UP TO THE MAN'S DEATH.....	8
THE DISCOVERY OF THE MAN'S DEATH	13
CONTACT WITH THE MAN'S FAMILY	16
CLINICAL REVIEWS	17
FINDINGS AND CONCLUSIONS	18
RECOMMENDATIONS.....	22
RECOMMENDATIONS FROM CLINICAL REVIEW	23

SUMMARY

The man was remanded into HMP High Down on 19 April 2006, charged with attempted murder. The man's co-defendant was remanded into High Down at the same time. This was the man's first time in prison custody.

During the standard prison reception procedures, the man revealed that he had committed acts of self-harm in the past, but said these had occurred some years ago. His answers to the various questions indicated that none of the acts had been serious suicide attempts. The man said that his last act of self-harm had followed a domestic argument. He also said that he had no current thoughts of self-harm or suicide.

During reception health screening, the man reported that he drank 12 to 14 cans of lager each day. He was prescribed medication for alcohol detoxification and placed in the prison's healthcare unit for observation.

The evidence of healthcare staff indicates that the man gave them no cause for concern. That said, he made it clear from very early on that he wanted to transfer out of the healthcare unit to a standard prison wing. A doctor assessed the man on the morning of 21 April and deemed him fit for transfer. This was his second full day in healthcare and it was just a matter of time for the necessary arrangements to be made for his transfer.

One of the other prisoners in healthcare has said that the man spoke to him during exercise that afternoon and told him that he could not take any more. The prisoner did not pursue the conversation with the man or report it to staff.

The man's co-defendant said that he was walking past the healthcare unit at about 4pm on 21 April when the man shouted across to him that he would be seeing him soon.

At about 4.30pm, the man telephoned his uncle. The man told his uncle that he was due in court in a week. He asked his uncle to tell his family and his partner that he was in High Down and to say that he was alright.

The man ate his evening meal at around 6pm. At about 7pm, he asked a healthcare assistant for some hot water so he could make tea. At 7.30pm, an officer was checking all the prisoners in healthcare when he found the man slumped against the back wall of his cell. The man had a ligature around his neck that was tied to the window frame. The officer freed the man from the ligature and healthcare staff attempted to resuscitate him. When ambulance paramedics arrived, they continued with the resuscitation efforts and they then took the man to Epsom General Hospital. At hospital, clinicians managed to obtain a pulse and the man was placed on life support. Unfortunately, tests showed that the man was clinically dead, so life support was withdrawn. The man was pronounced dead at 11pm.

Following the man's death a letter was found in his cell addressed to his partner. In the letter, the man reminded his partner that he had told her that he would not reach 40. On the day of his death, the man was 17 days away from his 40th birthday.

My report makes five recommendations.

INVESTIGATION PROCESS

The investigation was opened on 27 April 2006, when two of my investigators visited High Down. They met a number of prison staff, including the Governor, the head of healthcare, a chaplain and a representative from the Prison Officers' Association. They also met a member of the Independent Monitoring Board (IMB). My investigators informed the staff of the nature and scope of the investigation. Notices were issued to staff and prisoners notifying them of the investigation. My investigators subsequently interviewed both prison officers and clinical staff who dealt with the man. They also spoke with several prisoners.

East Elmbridge and Mid Surrey PCT agreed to carry out a review of the man's clinical care and treatment at High Down. The Prison Health Unit of the Department of Health carried out a review of the man's alcohol detoxification programme.

One of my Family Liaison Officers telephoned the man's uncle to inform him of the investigation and subsequently wrote both to the man's sister and to his partner. The man's family did not wish to raise any issues of concern with this office.

HMP HIGH DOWN

HMP High Down was built on the site of a former psychiatric hospital and opened in September 1992. High Down initially operated as a category A local prison but was re-categorised to a category B prison in 2003. It holds just over 700 prisoners.

High Down's regime includes education, catering, workshops, hairdressing and painting and decorating courses. Accredited courses include enhanced thinking skills and core sex offender treatment programmes.

There is a healthcare centre providing 23 in-patient beds supported by 24 hour nursing cover. A range of primary care services is also available for prisoners.

The most recent inspection of High Down by Her Majesty's Chief Inspector of Prisons (HMCIP) was an unannounced inspection in November 2004. HMCIP's report of her findings included:

'Arrival into custody procedures were generally sound and well managed ...

'On reception, staff engaged positively with prisoners. Although reception was essentially 'process' driven, due to the large numbers [of prisoners] involved ... efforts [were made] to put prisoners at their ease and to explain procedures ...

'There had been a significant improvement in the provision of healthcare services ... since the last inspection. A combination of integration into the PCT and new management at governor and healthcare manager level had provided the catalyst to implement change ...'

EVENTS LEADING UP TO THE MAN'S DEATH

The man was arrested on the evening of 2 March 2006. Together with a friend, the man was accused of attempted murder following an incident that had occurred the previous day. After spending the night in police custody, the man was released on bail on 3 March. He man was rearrested on 18 April ahead of a court appearance set for the following day. On 19 April, the man was taken from Bromley Police Station to Bromley Magistrates Court where it was decided that he should be remanded into prison custody. The man was taken from the Magistrates' Court at around 5.20pm and arrived at High Down that evening. The man's friend and co-defendant was received into High Down at the same time.

One of the documents with which the man arrived at High Down was a Prisoner Escort Record (PER) form. This form is completed when one agency, such as the police, pass a prisoner on to another agency such as the Prison Service. The PER highlights possible risk factors applying to an individual prisoner, such as the possibility that he might be violent, have drug or alcohol related problems or be at risk of suicide or self-harm. The man's PER had been ticked by the police to indicate a risk of suicide or self-harm. This assessment was based on information obtained when the man was first arrested by the police on 2 March. He had been asked that day whether he had ever tried to harm himself. The man replied that on several occasions he had either taken an overdose or had cut himself.

At High Down, a reception nurse saw the man to carry out a first reception health screening interview (this is a standard process for people arriving in prison). The Reception Nurse told the investigators that she remembered the man. She said that he was partially deaf and he told her that she would have to shout for him to be able to hear. Part of the health screening process includes enquiries about use of alcohol. The man said that he drank 12 to 14 cans of lager each day. The process also explores suicide/self-harm. The man said that he had taken an overdose two years before. The Reception Nurse said that the man was a bit vague in terms of detail of this incident, but told her that it had not been a serious suicide attempt. Where a person has answered yes to a question about certain of the questions on self-harm, staff are directed to refer them for a mental health assessment. The Reception Nurse said that she did not refer the man for mental health assessment as his reported level of alcohol consumption meant that he would have to be located into the healthcare unit for detoxification. A 'Wellman' assessment and mental health assessment would be followed through there.

The health screening assessment also explores present thoughts of self-harm. The question asked is: *'For some people, coming into prison can be difficult and a few find it so hard they may consider harming themselves. Do you feel like that?'* The 'yes' box was ticked in answer to this question. In interview, the Reception Nurse acknowledged that it was a mistake for her to have ticked the 'yes' box. The man had said that he was anticipating that prison would be difficult, but he was not thinking about harming himself. The Reception Nurse entered the following

assessment onto the man's health screening form: *'Appears stable in mood [and] behaviour. Has said he will probably find it hard to cope in prison, but will just get on with it. Has no thoughts of suicide/self-harm.'* The Reception Nurse told the investigators that, in making her assessment, she does not solely rely on the answers given to the questions about suicide/self-harm. She also takes account of the person's facial expression and their non-verbal behaviour. If she has any concerns that someone might be at risk of self-harm, she will open an ACCT (Assessment, Care in Custody and Teamwork) form¹ for them to be subject to special monitoring.

Following his health screening assessment, the man was seen by the Reception Officer who told my investigators that he had worked for the Prison Service for 11 years, the last year of which he had spent in reception. The Reception Officer said that he could not really recall the man. However, in his experience, the police usually ticked the suicide/self-harm box on the PER even if the last incident of self-harm had occurred many years in the past. The Reception Officer said that he asks prisoners if they have current thoughts of self-harm. If the answer to that question is 'no', he asks them if they would tell staff if they had such thoughts. The Reception Officer said that he would have made an entry in the man's records if he had said that he was considering harming himself.

The man saw two other people that day who also explored the issue of suicide/self-harm. The Meet and Greet Officer recorded that he judged the man not to be at risk of suicide and not to be at risk of self-harm.

Next, the man was seen by the First Night in Prison Officer who further explored suicide/self-harm issues. The man reported that his last act of self-harm had occurred two to three years before. He had taken an overdose following a row with his partner. The First Night in Prison Officer recorded that the man denied having any current thoughts of self-harm or suicide. He also recorded that he was satisfied that the man was not at risk of self-harm.

After the man had finished with the reception process, a doctor wrote out a prescription for chlordiazepoxide for alcohol detoxification and admitted him to the healthcare unit for observation.

At about 10am the following day (20 April), the man received a 'Wellman' health assessment. This was carried out by a registered mental health nurse, the RMN. The RMN told the investigators that the assessment would have taken almost an hour to complete. She said that the man was very polite, was softly spoken and made good eye contact with her. The man asked her how long he would need to remain in healthcare as he wanted to go to normal location. The RMN told the man that, as he was going through alcohol detoxification, he would need to stay in healthcare for up to five days. She said that the man was not upset on hearing that news. In answer to a question about his past medical history, the man said that he

¹ ACCT has replaced the F2052SH process for monitoring prisoners judged at risk of self-harm or suicide.

had taken an overdose of methadone 10 years before. However, he added that it was an accident and that he had not intended to harm himself. A section of the 'Wellman' assessment covers the person's mental state. The RMN noted on the assessment form that the man was in a stable mood. She told my investigators that there was nothing to indicate to her that the man might take his own life.

The Healthcare Nurse told my investigators that she first met the man on 20 April. He was one of her patients and she saw him that day for observation, for assessment of his withdrawal symptoms and mental stability, and to give him his medication. The Healthcare Nurse said that people with severe withdrawal symptoms are affected both physically and mentally. However, this was not the case with the man. He appeared to be well and asked to move to an ordinary prison wing. The Healthcare Nurse said that the man repeated his request during the doctor's ward round that day, and after assessment the doctor found that he was fit to move. Unfortunately, there were no beds available in the wings and so the man had to remain in healthcare. The Healthcare Nurse said that there was nothing about the man's behaviour that day to give her any cause for concern. Nor had he been distressed at the thought of having to remain in healthcare a little longer. He was interacting with other prisoners during exercise and association, and he was eating and drinking well.

The Healthcare In-patient Manager told my investigators that he is a qualified nurse and is a very 'hands-on' person who considers himself a nurse first and a manager second. He said that his usual practice in the morning is to carry out a check of all the patients in healthcare. The Healthcare In-patient Manager explained that people who drink heavily can be at risk of fits when withdrawing. It is for this reason that prisoners needing alcohol detoxification are located in healthcare for the first seven to ten days of the programme. (He added, however, that this is not a hard and fast rule.) The Healthcare In-patient Manager first met the man on the morning of 20 April, when he said that he did not want to be in healthcare and wanted to be transferred to a normal wing at the first opportunity. The man said that he was not an alcoholic and had not had a drink for several days before coming into High Down. He said that he did not understand why he needed to be in healthcare.

The Healthcare In-patient Manager believed that his next meeting with the man had been between around 2.00pm to 2.30pm on 21 April. Although there was nothing to indicate that the man was distressed, he reminded the Healthcare In-patient Manager that he wanted to leave healthcare. By then, the man had been seen by a doctor and found fit for transfer to normal location. The Healthcare In-patient Manager told the man that he would try to arrange a move that afternoon. As it turned out, other commitments prevented the Healthcare In-patient Manager from being able to arrange the transfer. He made an entry in the man's records: *'[The man] is very well today. He is ready to go to houseblock but we have been unable to locate today.'*

One of the other prisoners in the healthcare unit told the investigators that the man had spoken to him during exercise on the afternoon of 21 April. The man had said something along the lines of: *'I don't think I can take any more of this.'* This prisoner

told my investigators that this was his first time in prison and he was feeling nervous, and he did not say anything in reply to the man's comment. He thought that the man might have expressed the same concern to another prisoner and he gave my investigators a forename for that prisoner.

In the time that the man was in High Down, the only prisoner in healthcare with the forename suggested was not a patient, but was a prisoner orderly who worked there. The orderly told my investigators that he did not have any conversation with the man; their only contact had been when he gave the man a teabag at about 7pm on 21 April.

The man's co-defendant, as already mentioned, had also been remanded into High Down and been located in a normal wing as he did not have an alcohol problem. The man's co-defendant told my investigators that he had known the man for around four years. At around 4pm on 21 April, he was walking past healthcare on his way to the visits hall. The man called out: *'I'll be seeing you soon.'*

At just after 4.30pm on 21 April, the man telephoned his uncle to tell him that he was on remand in High Down and due in court the following week. The man asked his uncle to pass this news to another family member and to his partner and to tell them that he was alright.

The Healthcare Nurse said that she had seen the man using the telephone that afternoon. She had also seen the man out on exercise for almost an hour earlier on in the day. Throughout the day he had been chatting and laughing. There had been nothing about his behaviour to give any cause for concern.

The Agency Nurse told my investigators that she had started working shifts at High Down about six weeks before the man's death. She was uncertain when she first met the man, but clearly remembered meeting him at around 5pm to 5.30pm on 21 April. She said that she was issuing medication that afternoon and, when she reached the man's cell, he was lying on his bed. She called to him and he came to the door to take his medication with some water, which she handed through the door hatch. The Agency Nurse said that the man seemed okay. He thanked her for his medication, but they exchanged no real conversation.

The Healthcare Officer² told my investigators that he had worked in the healthcare in-patients unit for about two and a half years and that he was still in training. The Healthcare Officer said that there had been nothing about the man's demeanour to cause him any concern. The man was laughing and joking and spoke both to staff and other prisoners. The Healthcare Officer said that he had helped the man make the telephone call to his uncle at 4.30pm as he had been uncertain how the

² A healthcare officer is a prison officer who has received some additional clinical training. They are not registered health professionals

telephone system worked. At about 6pm, the Healthcare Officer delivered the man's evening meal which he ate.

The first Healthcare Assistant told my investigators that he was not on duty on 19 and 20 April, but started a late shift at 1pm on 21 April. As usual, the shift started with a nursing handover when the morning staff briefed the on-coming staff about all the patients in healthcare. They were told that the man was in healthcare for alcohol detoxification, but he had been passed fit for transfer to normal location and was waiting for that to be arranged. The first Healthcare Assistant said that he saw the man during afternoon association when he was chatting to and interacting with, the other prisoners. The only conversation that the first Healthcare Assistant had with the man was at around 7pm, when he asked for some hot water so he could make tea. The first Healthcare Assistant told the man that he would start distributing hot water once he had finished his observations of those prisoners subject to special monitoring (that is, prisoners subject to monitoring under the ACCT process).

THE DISCOVERY OF THE MAN'S DEATH

At about 7.30pm on 21 April, the Healthcare Officer decided that he would check all the prisoners in healthcare. This was not a scheduled check and was just something that the Healthcare Officer chose to do at that time. The Healthcare Officer said that the man's cell was unlit. When he switched on the light he saw the man in a sitting position against the back wall of the cell. The Healthcare Officer called his name, but got no response. The Healthcare Officer said that he shouted for help, unlocked the cell door and radioed for assistance. The man had used a jumper to make a ligature and he had tied this to the window frame. The ligature knot was very tight and the Healthcare Officer was unable to untie it.³ The Healthcare Officer then lifted the man's body, upon doing which the ligature came undone. The Healthcare Officer laid the man onto his bed, by which time medical assistance had arrived in the cell. The Healthcare Officer told my investigators that the reason he placed the man onto the bed, rather than onto the floor,⁴ was because he had had to lift the man quite high up to release the ligature. By the time the ligature came away, he no longer had sufficient strength left to lower him to the floor. The Healthcare Officer said that two or three nurses arrived and so he left it to them to start treating the man.

The nurse who was the Emergency Response Nurse that evening said that when he heard the Code 1 alert he rushed to the in-patients unit. When he arrived, two other nurses – the Agency Nurse and the second Healthcare Assistant – were standing by the man's cell door. They followed him into the room. The man was lying on his bed; he appeared blue in colour and was not breathing. The Emergency Response Nurse said he is aware that, ideally, CPR should be carried out with the patient lying on the floor. However, the seriousness of the man's condition did not allow time to move him from his bed onto the floor. Instead, the Emergency Response Nurse immediately started attempts to resuscitate the man where he was lying. He also asked for the ambulance service to be contacted. This call was noted as made at 7.35pm. The Emergency Response Nurse continued with CPR until he became tired when the Principal Officer (the Orderly Officer⁵) relieved him. The Agency Nurse and the second Healthcare Assistant also assisted with the efforts to try to resuscitate the man. The Emergency Response Nurse said that he tried to use a defibrillator to check whether an electrical shock should be given, but the man's chest was too hairy for the defibrillator's sensors to obtain a reading.

The Agency Nurse said that at about 7.30pm she was standing by the unit bathroom answering a question she had been asked by the second Healthcare Assistant. At

³ At the time of Mr The man's death, staff at High Down did not carry anti-ligature knives as an item of standard equipment.

⁴ Cardio-pulmonary resuscitation (CPR) is most effectively performed when the patient is lying on a hard surface.

⁵ The Orderly Officer carries the call sign Oscar 1 and is the officer in charge.

that moment, the Healthcare Officer came out of one of the cells and shouted for assistance. The Agency Nurse said that she and the second Healthcare Assistant rushed to the cell. The Agency Nurse said that when she arrived she first helped the Healthcare Officer to position the man onto his bed. She then checked for a pulse, but found none. The Agency Nurse said that the man's face was bluish in colour. She then helped to remove the man's T-shirt so that the defibrillator could be used. At that moment, the Emergency Response Nurse arrived and started to carry out CPR. The Agency Nurse said that she then went to help prepare the oxygen cylinder. In contrast to the Emergency Response Nurse's recollection of events, the Agency Nurse thought that it had been possible to use the defibrillator to check the man. She said that she could recall the defibrillator instructing that people should stand away from the man, but she could not recall whether the machine instructed to shock or not to shock.⁶

The first Healthcare Assistant told the investigators that he had helped in giving CPR to the man. He said that he had taken the defibrillator to the man's room. When it was connected to the man, it instructed not to shock.

The second Healthcare Assistant told the investigators that she had worked at High Down since February 2006. She gave the same evidence as the Agency Nurse about being called by the Healthcare Officer. She said that, when she arrived in the man's cell, she panicked. She did not think about starting CPR on the man. Instead, she was thinking about collecting an oxygen cylinder. It was at this point that the Emergency Response Nurse arrived and commenced CPR.

The Healthcare Nurse told my investigators that she was the senior nurse on duty on the evening of 21 April. At the time that the man was found hanging, she was completing reports on the patients ahead of the night staff coming on duty. The Healthcare Nurse said that, when she arrived, the Emergency Response Nurse was present and was performing CPR. The Healthcare Nurse said that the Principal Officer asked if a doctor had been called and she went to the unit office to check the name of the out-of-hours on-call doctor. When she telephoned this doctor, he said he was not on-call that evening. The Healthcare Nurse pleaded for him to attend even if he was not on duty, but he would not do so. The Healthcare Nurse said that she put the telephone down and returned to help with the attempts to resuscitate the man. The Healthcare Nurse said that, when the ambulance paramedics arrived (records show that they arrived at High Down at 7.52pm), they took over the efforts to try to resuscitate the man and this included inserting a tube to help in giving him oxygen. The paramedics then took the man to hospital.

The ambulance left High Down at 8.20pm and arrived at Epsom General Hospital at 8.35pm. Hospital clinicians were able to obtain a pulse from the man and he was placed on life support. However, tests showed that the man was clinically dead and so life support was withdrawn. The man was pronounced dead at 11.00pm.

⁶ An automatic external defibrillator has sensors that are placed on the patient's chest. It detects electrical activity in the heart and issues audible instructions about treatment.

The Healthcare Manager told my investigators that GP services at the prison are provided through Sussex Forensic Medical Services (SFMS). SFMS provides day-time cover and out-of-hours call-out cover at night and at weekends. In the case of out-of-hours cover, SFMS give High Down a rota of the on-call doctors. Following the difficulty with identifying and summoning the on-call doctor on the night of the man's death, the Healthcare Manager informed SFMS of the problems High Down encountered.

In a statement about his involvement, the Principal Officer confirmed that he had assisted in providing CPR to the man – he had taken over from the Emergency Response Nurse when he became tired. The Principal Officer had also attempted to summon the out-of-hours on-call doctor but had encountered the same problem as the Healthcare Nurse.

When the man's co-defendant met the investigators he told them that his wife had spoken to him about the man's death. She told him that the prisoner in the cell opposite the man's had seen him hang himself. This prisoner had supposedly called out to staff but no-one had responded. The co-defendant's wife had heard about this from the prisoner's mother. The investigators spoke to this prisoner. He said that he did not see the man hang himself but had seen staff attempting to resuscitate him. The prisoner said that he thought that the staff had done well. When the investigators looked through this prisoner's cell door observation panel, they could see into the man's cell. However, they could only see part of the back wall of the cell. They could not see the cell window to which the man had tied the ligature and it would not, therefore, have been possible for the prisoner to have seen the man hanging.

In his interview, the man's co-defendant also told my investigators that he thought the man might have been worried about his partner as she had ended a previous relationship when her then partner had gone to prison. The co-defendant thought that the man might have been worried that the same thing might happen to him (officers were not aware of this information).

After the man's death a letter was found in his cell that he had written for his partner. Among other things, the man wrote: *'I told you Angel I will not get to 40. Love you always ...'* He ended the message by writing: *'I [love you] so much I can't live without you.'*

CONTACT WITH THE MAN'S FAMILY

At 9.20pm on 21 April, a Chaplain from High Down telephoned the man's uncle to say that his nephew was in hospital. Fifteen minutes later, the Chaplain telephoned again with the additional information that the man was on life support. At 11.15pm, the Chaplain telephoned a third time to report that his nephew had died at 11.00pm. But the man's uncle was already aware of this news as he had telephoned the hospital himself.

The following morning, another of the prison Chaplains telephoned the family with some information about the circumstances surrounding the man's death.

High Down's Family Liaison Officer subsequently contacted the man's family. An offer was made for them to visit High Down and to see the man's cell. The family decided that they did not wish to take up this offer.

High Down paid for the man's funeral expenses.

The man's co-defendant was offered support. Healthcare staff were offered the chance to speak to the prison's care team.

A post mortem examination of the man's stomach contents included some part digested food and also a plastic bag. The pathologist found no obvious contents within the bag and no tablet residue within the man's stomach. The bag and a blood sample were sent for toxicological examination. The results of these examinations were not available at the time the final report was issued to HM Coroner, the Prison Service and the man's family. It was subsequently reported that no illicit substances had been detected.

CLINICAL REVIEWS

Two clinical reviews were obtained in this case. A senior nurse from East Elmbridge and Mid Surrey PCT carried out a review of the man's clinical care and treatment. The Prison Health Unit of the Department of Health carried out a review of the man's alcohol dependence management.

The PCT reviewer's findings include criticism of the standard of record keeping. The reviewer refers to the illegibility of staff signatures and the use of clinical abbreviations in the man's records which would not be universally understood. The reviewer has made recommendations on both of these matters. The reviewer has also pointed out that some of the entries made in the man's records are inconsistent with others made earlier on. The reviewer's third recommendation is that there should be a further investigation into the non-attendance of the on-call doctor when the man was found hanging.

The review into the man's alcohol dependence management comments on the lack of objective measures, such as repeated blood pressure and pulse readings, to indicate how the man was coping with the prescribed detoxification programme. However, this review also refers to entries in the man's records that suggest he was coping well.

FINDINGS AND CONCLUSIONS

When the man was received at High Down on 19 April, it was his first time in prison custody. He arrived in High Down with a Prisoner Escort Record form that had been ticked by the police to show a risk of suicide or self-harm. This warning followed from the man reporting that he had harmed himself on several occasions in the past.

As in every prison, the reception process at High Down explores issues surrounding suicide or self-harm. The man had separate assessments with a reception nurse, a reception officer and an officer who completed a first night in prison form. One of the components of each of these assessments is about suicide and self-harm. As he did when in police custody, the man revealed that he had committed acts of self-harm in the past. However, he also said that he had no such thoughts at the present time. The man was also seen by one other officer that evening. Any of the four staff involved could have opened an ACCT form if they had deemed the man at risk of self-harm. None of them considered him to be so, and I am satisfied that this was reasonable, based on the evidence before them at the time.

During his first reception health screen, the man had reported that he drank 12 to 14 cans of lager each day. As a result, he was prescribed chlorthalidone for alcohol detoxification and was located into the healthcare unit.

There is great consistency in the evidence of all the staff with whom the man came into contact while he was in healthcare. None of them felt there was any cause for concern for his safety. On the morning of 20 April, the man spent almost an hour with the RMN for completion of a Wellman assessment. The man told the RMN that he had taken an overdose many years before, but said that it had been accidental and that he had not intended to take his life.

The man's one clearly expressed concern while he was in healthcare was that he wanted to be relocated to a standard prison wing – possibly so that he could be with his friend and co-defendant. The man told staff that he had not had a drink for several days before coming in to High Down, and so did not understand why he needed to remain in healthcare. Although it is clear from the evidence of staff that the man was eager to be relocated, staff also said that there was nothing to suggest that he was in any way distressed during his time in healthcare. In any case, the doctor had deemed him fit for transfer to ordinary location on the morning of 21 April, so it was then only a case of awaiting the necessary arrangements. The man spoke to the Healthcare In-patient Manager about his transfer. In theory, the man might have moved that afternoon. But as it turned out, the Healthcare In-patient Manager had not been able to find the time to deal with the matter that day.

At about 4pm that afternoon, the co-defendant was walking past healthcare when it seems the man must have caught sight of him. The co-defendant told my investigators that the man shouted over that he would be seeing him soon.

The man telephoned his uncle at just after 4.30pm on 21 April. It was an unremarkable conversation. The man merely wanted to tell his uncle where he was. He asked his uncle to pass the news on to other family members, and to his partner, and to tell them he was alright.

The only indication that the man might have been at risk of suicide or self-harm came from the evidence given by one of the other prisoners. He told my investigators that the man spoke to him during exercise on the afternoon of 21 April and said something along the lines that 'he could not take any more'. This prisoner told my investigators that he did not continue the conversation. He said that it was his first time in prison, he was feeling nervous and so he walked away. The prisoner thought that the man might have spoken about the same issue to another prisoner and he suggested a forename for that prisoner. The only prisoner with the name suggested denied having had such a conversation with the man.

The last time the man was seen alive was at 7pm. The man was given a tea bag by a prisoner orderly and he asked the first Healthcare Assistant for some hot water.

At 7.30pm, the Healthcare Officer was checking prisoners when he saw the man in a sitting position at the back of his cell. The man failed to respond to his name being called, and so the Healthcare Officer shouted for help, entered the cell and then radioed for assistance. He found the man with a ligature around his neck that he had tied to the window frame. The ligature knot was very tight. However, when the Healthcare Officer pulled the man off the floor to relieve pressure from the ligature, the knot came undone. The Healthcare Officer lowered the man onto his bed. At this point nursing staff arrived.

I recommend that all clinical healthcare staff should receive annual updating of resuscitation skills in line with the recommendations of the Resuscitation Council UK.

As is often the case in emergency situations, there is a degree of inconsistency in the evidence given by those involved. It is clear that the Emergency Response Nurse took control of the situation and played a pivotal role in the attempts to try to resuscitate the man. However, part of the Emergency Response Nurse's evidence was that he was the first nurse to reach the man. He said that the Agency Nurse and the second Healthcare Assistant were standing outside the man's cell and they then followed him. In her interview, the second Healthcare Assistant acknowledged that she panicked. She said that she did not think about commencing CPR on the man – at the point that the Emergency Response Nurse arrived she was thinking about collecting an oxygen cylinder. The Agency Nurse said that she responded immediately to the Healthcare Officer's call for assistance. She said that she went straight into the man's cell and removed his T-shirt so the defibrillator could be used. She said that it was only at this point that the Emergency Response Nurse arrived.

It is also unclear whether or not staff were able to assess the man with the defibrillator. The Emergency Response Nurse said that the sensors would not attach properly to the man as his chest was too hairy. Other staff thought that the defibrillator was attached to him, but it advised not to shock. In any case, staff continued trying to resuscitate the man until the ambulance paramedics arrived at just before 8pm. The man was then taken to hospital where clinicians were able to obtain a pulse. The man was placed on life support, but tests showed that he was clinically dead. He was officially pronounced dead at 11.00pm.

In addition to the confusion noted above, there are two other matters on which I must comment in relation to the attempts to resuscitate the man. The first matter is where CPR was carried out. It is acknowledged that CPR is most efficiently delivered when the patient is lying on a hard surface. The Healthcare Officer said that he was aware of this, but having lifted the man to release the ligature from his neck he had no strength left to lower the man to the floor. As a result, he laid him onto his bed instead. The Emergency Response Nurse said that the man was not breathing and his body was blue in colour. There was therefore no time to transfer the man from the bed onto the floor and he started CPR with the man where he had found him. While the ideal would have been for staff to have moved the man onto the floor, I can understand why this did not happen. I am also conscious that my investigators observed that the man's mattress was thin and hard.

The Governor should ensure that the prison complies with Prison Service Instruction 36/2006 which requires anti-ligature knives to be carried as a standard item of equipment by all staff whose function means that they might be first at the scene when a prisoner is found hanging.

The second matter on which I must comment is the unsuccessful efforts to contact the out-of-hours on-call doctor. Both the Healthcare Nurse and the Principal Officer telephoned the doctor whose name was listed on the duty rota. However, he told them that he was not the doctor on-call. The Healthcare Manager subsequently contacted SFMS (the providers of GP services at High Down) to inform them of the difficulty that occurred. I endorse the recommendation of the clinical reviewer. As the commissioner of healthcare, I believe that East Elmbridge and Mid Surrey PCT should undertake an urgent review of the on-call provision available at the prison. The non-attendance of the on-call doctor should be investigated by the PCT and SFMS and, if necessary, further action taken.

After the man's death, a letter was found in his cell addressed to his partner. The man reminded her in the letter that he had told her that he would not reach 40 – the man's 40th birthday would have been on 8 May 2006.

With the benefit of hindsight, it is possible to identify a number of risk factors. The man was in prison for the first time and had been in custody for just two days. He had been charged with a violent offence. It was known that he had committed acts of self-harm in the past (although he told a number of different members of staff that he

had no such thoughts at present). He was undergoing alcohol detoxification. These are all risk factors for self-harm. Nevertheless, there was nothing specific about his behaviour to alert staff that he was considering taking his own life, and I do not believe there were sufficient grounds for any member of staff to have opened a self-harm monitoring and support form (ACCT).

Whether or not the man intended to take his life will be a matter to be decided at inquest. However, the man's letter to his partner is clearly significant. I also find it significant that, when the man arrived at High Down, he reported that a drugs overdose he had taken two or three years before had followed a row with a partner. Interestingly, the evidence given by the co-defendant included that the man might have been worried that his partner could end their relationship because of his imprisonment.

RECOMMENDATIONS

The following recommendations were made in the draft version of this report. The Prison Service's response is included in italics following each recommendation:

1. All clinical healthcare staff should receive annual updating of resuscitation skills in line with the recommendations of the Resuscitation Council UK.

Recommendation accepted locally: All staff have received resuscitation skills training including defibrillation from Surrey Ambulance Service Community Trainer. However as from Jan 2007 this situation has changed and an individual from the Resuscitation Council will be undertaking all the resuscitation training. A date in February 2007 has already been arranged for the first update and to train new recruits to the service.

2. The Governor should ensure that the prison complies with Prison Service Instruction 36/2006 which requires anti-ligature knives to be carried as a standard item of equipment by all staff whose function means that they might be first at the scene when a prisoner is found hanging.

Recommendation accepted: Anti-ligature knives have been purchased and are being issued to staff in line with guidance in Prison Service Instruction 36/2006 (it should be noted that this Instruction was issued after the death of the man and is a new policy).

Recommendations from the Clinical Review

3. A signature sheet should be included in all case notes to identify staff members' entries.

Recommendation accepted: This is a requirement by the Nursing and Midwifery Council in HMP Highdown's Code of Conduct. Regular training updates happen with staff to reinforce the legal aspects of nursing.

4. Clinical abbreviations in case notes should follow cross service standards.

Recommendation accepted: Abbreviations are actively discouraged because of the legal requirements in documentation in line with the Code of Conduct.

5. The non-attendance of the on-call doctor should be investigated by the PCT and SFMS and, if necessary, further action taken to address the refusal of the on duty doctor to attend.

Recommendation accepted: A meeting took place with SFMS and HMP Highdown have regular meetings with the Director to monitor the contract against the service specification. On the night in question, the doctor who was on the rota had swapped his shift without informing the administration at SFMS therefore a new rota had not been produced demonstrating changes. The management at SFMS have met with their staff and there have been no further incidents.